

## **Medicare Prescription Drug Coverage Information Form**

## Please complete the information below and provide <u>one</u> of the following:

- 1. Print-out from pharmacy with a list of drugs you currently take OR
- 2. The most recent "Explanation of Benefits" from your Medicare Part D Drug Plan OR
- 3. Bring all of your prescriptions (e.g. bottles, inhalers, creams, etc.) when you meet with a SHIIP Counselor.

1. What is your name on your <b>Medicare</b> card and a	ddress on record with Medicare?	
First Name M.I. Last Name		
Address		
City	Zip Code	
Phone Number	County	
2. What is your Medicare Claim Number on your Medicare card?		
3. What is your Medicare effective date(s)?	MEDICARE HEALTH INSURANCE  SOCIAL SECURITY ACT	
	MAME OF BENEFICIARY JOHN D. DOE MEDICARE CLAIM NUMBER SEX	
Part AMonth Day Year	123-45-6789A MALE IS ENTITLED TO EFFECTIVE DATE	
Part BMonth Day Year	HOSPITAL INSURANCE (PART A) 1/1/95 MEDICAL INSURANCE (PART B) 3/1/99 SIGN HERE JOHN D. DOE	
4. What is your date of birth?	SHIIP Office Use Only:	
	Enroll after Oct 15 🔲 Enrolled 🗆	
Month Day Year	Male □ Female □	
5 What is your F-mail address? (ontional)	Premium Payment: SSA □ Direct Bill □	
5. What is your E-mail address? (optional)	Drug List ID:	
	Password Date:	
- OVER-	Month DateYear	

Name of Pharmacy Address and City Phone Numb	oer
Name of Pharmacy Address and City Phone Numb	per
11. What pharmacy do you prefer? You may list two.	
(Note: Resources include items you own by yourself or with someon include your home, vehicles, burial plots or personal possessions.)	ne else. Don't
<ul> <li>You may be eligible to get extra help with your prescription drug costs. income and resources below:</li> <li>Single: Income \$16,335 Resources: \$12,640</li> <li>Married: Income \$22,065 Resources: \$25,260</li> </ul>	
If you checked one of the boxes in number 9, skip quest	<u>ion 10.</u>
Pay \$2.50 for generics and \$6.30 for brand name drugs	
Pay \$1.10 for generics and \$3.30 for brand name drugs	
Extra help with your Medicare drug costs	
Medicaid (Title 19) Help paying your Medicare Part B premiur	n
9. Do you currently receive any of the following benefits?	
Medicare drug plans Medicare Advantage Plans Both	
8. How would you like to receive your Medicare drug benefits? You can g Medicare prescription drug coverage by enrolling in a Medicare stand- OR a Medicare Advantage Plan which provides your Medicare Part A a Part B benefits. Please provide a comparison of (check one):	alone drug plan
Federal Employee Health Benefits Plan	
Name of Plan VA TriCare	
None Medicare Part D or Medicare Advantage Plan:	
7. What is your current drug coverage?	
(People with permanent kidney failure are not eligible to join a Medicare Ad	lvantage Plan.)
6. Do you have End Stage Renal Disease? Yes	